Mental Health System Transformation Initiative Implementation



Washington State
Department
of Social
& Health
Services

STI Task Force Meeting
December 21, 2006

Fall Community Forum Recap

- 150 participants registered;120+ attended
- Participants represented:
 - Consumers
 - Family members
 - RSNs
 - Inpatient and community mental health providers
 - State hospitals
 - Housing providers
 - MHD and other state agencies
 - STI Contractors
 - Other stakeholders (e.g., CD providers, clubhouses, county govt, other advocacy group)



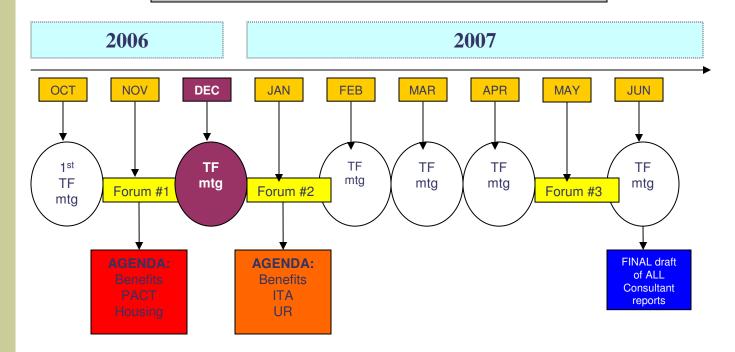
Fall Community Forum Recap (cont.)

- Participants were asked to rate the November Community Forum on a scale of 1 ("very poor") to 4 ("very well").
- Average rating for the Forum was 3.47 "well" to "very well."
- Solicited feedback on three of the five STI initiatives:
 - Medicaid Benefits Package Redesign
 - PACT Implementation
 - Housing Action Plan





STI Task Force & Community Forum Timeline





Washington State System Transformation Initiative: Review of Involuntary Treatment Laws

December 21, 2006

Jenifer Urff, J.D. Advocates for Human Potential, Inc.

System Transformation Initiative

- Statewide implementation of PACT Teams
- Statewide mental health housing plan (Common Ground)
- Review of mental health benefits package (TriWest)
- Review of involuntary treatment laws (TriWest)
- Utilization Review for psychiatric inpatient services

Consultant Background

- Advocates for Human Potential, Inc. (AHP)
 - New Freedom Initiative/Olmstead Initiative to promote community integration
- National Association of State Mental Health Program Directors (NASMHPD) (1998-2003)
 - Government Relations
 - Legal Division/Forensic Division
 - Kansas v. Crane
 - Kendra's Law
 - MacArthur Study on Mental Illness and Violence
 - Olmstead v. L.C.

Consultant Background (cont.)

TriWest Group

- Based in Boulder, CO and Seattle, WA
- Helped Clark County, Thurston-Mason RSNS with RFQ/P
- Involved in numbers child system collaborations in King, Pierce, Spokane, Thurston, and Yakima counties
- Experience with Medicaid Benefit Design issues
- Understands Evidence-Based Practices and promising practices, including cross-cultural applications
- Expertise in Medicaid funding

Overview of Project: Review of Involuntary Treatment Laws

- Review specific provisions in State involuntary treatment statutes
- Compare specific provisions with other states' approaches
- Identify strengths, challenges, and options for reform

Operating Principles for Review of Involuntary Treatment Laws

- Improve balance of civil liberty and public safety
- Improve consistency across the state
- Ensure best use of inpatient and communitybased care to support recovery
- Identify best use of State Hospitals

Context and Focus for Review of Involuntary Treatment Laws

- MHD's desire to create a recovery-focused, resiliency-based system of care
- Specific focus on issues affecting State hospital utilization:
 - Process for initiating and implementing involuntary civil commitments in Washington State, especially for individuals who are arrested for misdemeanor crimes and are found to be not competent to stand trial
 - "Gravely disabled" definition
 - "Mental disorder" definition

Other Issues Related to Review of Involuntary Treatment Laws

- State hospital utilization and lengths of stay
- Age of consent
- Least restrictive alternatives/community service capacity
- Implications for tribal governments

Process for Review of Involuntary Treatment Laws

- Literature review/legal research (now underway)
- Stakeholder input (now underway)
 - Task Force meeting (December)
 - Community Forum to collect information from multiple stakeholders (January)
 - Focus groups as needed (December March)
 - Key informant interviews (January March)
 - State leaders: consumers, families, community providers, state hospitals, law enforcement, courts, advocates
 - Solicit input from all parts of the State
 - Interviews with national experts
- Comparisons with other states

Process for Review of Involuntary Treatment Laws (cont.)

Reports

- Preliminary Report (February, 2007)
 - Define scope of review
 - Articulate questions/issues presented
 - Discuss literature review
 - Identify states for comparison study
- Draft final report (May, 2007)
- Final Report (June, 2007)

Project Team for Review of Involuntary Treatment Laws

- Andy Keller, Ph.D., Project Director (TriWest)
- Jenifer Urff, J.D. (AHP)
- Alan Marzilli, M.A., J.D. (AHP)
- Jenna Ichikawa (TriWest)

Contact Information

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Part 5: External Utilization Review

What is Utilization Review?

- Process of assessing delivery of services to determine if care provided is
 - Appropriate
 - Medically necessary
 - High quality
- Includes review of appropriateness of
 - Admissions
 - Services ordered and provided
 - Length of stay
 - Discharge practices
- Concurrent and retrospective basis.



Part 5: External UR (cont'd)

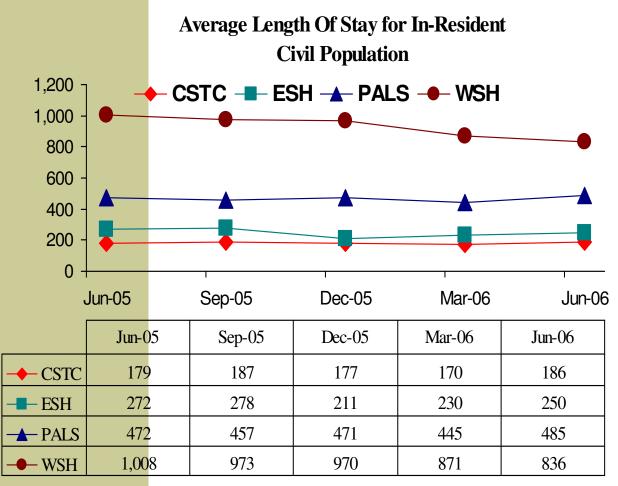
Current External UR for Psychiatric Inpatient Services

- RSNs required by contract to do UR for community inpatient days
- No external UR for State Hospital days (State Hospitals conduct their own UR process)



Objective: Patient Care is Recovery Based and Non-coercive

State Hospital Average Length of Stay for In-Resident Civil Population



Analysis

- Western average length of stay is 4 times the other hospitals
- Average LOS is slowly declining at Western State Hospital
- Eastern state hospital's stays may be shorter because it houses more 72 hour and 14day ITA commitments

Part 5: External UR (cont'd)

Scope of Planning Activities

- Establish acuity levels to be supported in community settings
- Develop sampling methodologies & processes for independent review of 90 and 180 day commitments
- Include State and community inpatient settings
- Identify resources required for statewide implementation
- Draft RFP for External UR services



Part 5: External UR (cont'd)

Expected Benefits

- Prevent over and under utilization of inpatient care
- Increase RSN & provider accountability
- Improve consistency for consumers throughout the state
- Identify state and local community resource gaps



Part 4: External UR (cont'd)

Brainstorm:

What are some key issues in the development of an external UR process that should be considered?



Part 4: External UR (cont'd)

External UR Questions in consideration for January Forum

- What advantages or benefits do you see in an external UR process?
- Do you have any concerns or issues you think we should keep in mind in considering an external UR process? How would you know that your concerns have been addressed?
- Where do you think the greatest benefit of an external UR process will be – community hospitals, state hospitals, or both?



Part 5: November Forum Follow-Up Discussion

- Housing Lynn Davison, Common Ground
- PACT Maria Monroe-DeVita, WIMIRT
- Medicaid Benefits: Andy Keller, TriWest Group



Mental Health Housing ACTION Plan



Legislative Intent SB 6793

Reduce utilization of state hospitals

Expand recovery oriented community-based care

Increase housing options for consumers

MHD Contract Deliverables

- ➤ Data collection/preliminary report Jan '07
- Draft Housing Action Plan April '07
- Final Report June '07
- > Technical assistance Feb June '07

Sources of Information

Community Forum input

Electronic Survey in 6 RSNs:

- ➤ NorthSound
- ➤ King
- **≻**Pierce
- **≻**Timberlands
- ➤ Chelan-Douglas
- **≻**Spokane

Sources of Information, cont.

On-site interviews in 6 RSNS

• 3 Statewide Focus Groups

 Review of relevant plans and polices: state and local

Input From November Community Forum

What Supports?

- Peer support / recovery strategies
- Landlord support/education
- Onsite services in community based housing
- Discharge planning: hospitals, jails, prisons
- Housing and service provider collaboration
- More resources for community-based housing
- More employment options

What Barriers?

- Housing Affordability
- Poor coordination of housing and service funders
- Felony convictions
- Release from jail and hospital
- Bad credit histories
- Cultural and language barriers
- Not enough jobs

What Outcomes?

- Tenant, patient and landlord satisfaction
- Length of stay in residence
- Reduction of hospital, jail days
- Reduction in evictions
- Reduction in numbers of homeless mentally ill
- Reduction in wait time for housing
- Increased housing options to fit diverse populations

Preliminary Report Outline

- Definition of Housing Action Plan
- II. Data Collection
- III. Key Findings from Washington
 - A. System strengths
 - B. System gaps/weaknesses
 - C. Estimate of housing needs

- IV. Relevant Findings from other places
- V. Preliminary Recommendations
 - A. Policies and Contracts
 - B. Financing
 - C. Models
 - D. Partnerships
 - E. Capacity building / TA

Technical Assistance

Provide Assistance to:

- RSNs
- Local housing and service providers

Goals:

- Develop increased capacity for providing housing for mental health consumers
- Develop additional housing units

Technical Assistance Activities

- February-June 2007
- Web based resources on housing models, financing and housing development
- Individualized assistance for specific organizations and projects
- Workshops and training for groups of RSN staff, and housing and service providers

Contact Information

Lynn Davison... (for Lynn to insert here)

System Transformation Initiative

PACT Implementation Task Force Update

December 21, 2006

Maria Monroe-DeVita, Ph.D.

The Washington Institute for Mental Illness Research & Training/
University of Washington

Update Overview

- Update on current PACT implementation processes
- Feedback from the Fall Community Forum
- 3. Initial thoughts for integration of Forum feedback into implementation processes
- 4. Suggested next steps from the group

Current PACT Implementation Efforts

- 1. Assembled a committee and process for reviewing Western RSNs' implementation plans
- Developed feedback reports to identify strengths, challenges, and recommendations
- Meeting with RSNs to begin collaboratively identifying initial training and technical assistance needs
- 4. Will begin same process with the Eastern RSNs, beginning in January 2007

Feedback from Fall Community Forum

THREE questions posed to this multi-stakeholder audience:

- 1. What outcomes are most important for PACT?
- 2. What concerns should we be watching for?
- 3. How do we ensure a person-centered, recovery-oriented model within the framework of PACT?

#1: What outcomes are most important for PACT?

- > Reduction in criminal justice involvement
- > Reduction in other high acuity services
- Increase in/better housing
- > Community and social integration
- > Increase in employment
- > Consumer satisfaction and quality of life
- Consumer engagement in recovery
- > Graduation from PACT

#2: What concerns should we be watching for?

- Not recovery-oriented
 - Goals identified by team vs. consumer
 - Coercive; not truly voluntary
 - Paternalistic/perpetuates learned helplessness
- Lack of an individualized approach
 - Service array is too uniform
 - Assumption of one size fits all
- External factors may prevent success
 - Not enough housing
 - Lack of secured, ongoing funding

#2: What concerns should we be watching for?

- > Program fidelity—some want it, some don't
 - Same old service, different name
 - Staffing model is too professionally-driven
- > Lack of cultural competence
- > Un-integrated peer specialists
- > Not available statewide
- > Concerns about admission criteria
 - Primary focus on only high service utilizers
 - Focus on consumers with fewer needs

- > Active consumer participation
 - Within PACT:
 - Recovery planning
 - Consumer preferences, goals, choices
 - Direct service provision
 - Full integration of peer specialist
 - More peer specialists
 - Outside of PACT:
 - Planning
 - Evaluation
 - Monitoring

- Team is person-centered in everything they do:
 - Recovery Planning; WRAP
 - Ensure goals are consumer's not the team's
 - No "one size fits all" goals
 - Services are driven by consumer choice
 - Strengths-based approach
 - Consumer choice in working/not working with particular team members

- Educate, empower, train consumers in recovery
 - Assertiveness skills in voicing preferences, choices
 - Importance of assuming responsibility for own recovery
 - Encourage, coach consumers in make own decisions/choices and the positive impact for them

- Creating a culture of recovery with PACT staff
 - Hire staff who espouse recovery values
 - Train staff in recovery
 - Ensure that peer specialists are fully integrated and provide cross-training
 - Educate the community about recovery
 - Adopt SAMHSA's National Consensus Statement on Mental Health Recovery

- Ongoing team monitoring & accountability
 - Evaluate whether the team is being personcentered and recovery-oriented
 - Examine consumer satisfaction and dissatisfaction
 - Evaluate quality of life indicators

Places of Impact on Next Steps

- Contract requirements with RSNs
- Washington State PACT Program Standards
- > Training and Technical Assistance
- Program Evaluation:
 - Program Fidelity
 - Outcomes

Next Steps: Recovery-Focused Training & Services

- Prioritize recovery training and ongoing education for all PACT staff and consumers
- Ensure that all clinical training in evidencebased approaches is person-centered & recovery-oriented
- Promote and monitor full integration of peer specialists on the team; provide mechanism for ongoing mutual support

Next Steps: Evaluation & Monitoring

- Support strong local PACT Stakeholder Advisory Group membership, participation, and ongoing feedback
- Incorporate assessment of recovery processes into fidelity tool
- Evaluate consumer recovery as part of outcome assessment:
 - Recovery scale
 - Satisfaction/dissatisfaction survey
 - Quality of Life measure

Other Next Steps:

- TA and ongoing monitoring of appropriate authorization, admission, and prioritization processes
- Staff training in cultural competence; Ongoing monitoring of Culturally and Linguistically Appropriate Services (CLAS)
- Prioritize training and technical assistance in housing acquisition and retention

What else would you add to next steps for PACT?

Contact Information

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Washington State System Transformation Initiative

Update on Mental Health Benefits Design Project



Andrew Keller, PhD **December 21, 2006**



Background on TriWest Group

- > Based in Boulder, CO and Seattle, WA
 - ✓ Helped Clark County, Thurston-Mason RSNs with RFQ/P
 - ✓ Involved in numerous child system collaborations in King, Pierce, Spokane, Thurston and Yakima counties
- Experience with Medicaid Benefit Design issues:
 - ✓ Pennsylvania Comparison to three other states (AZ, CO, MA); currently helping with State Plan Amendments; promoting recovery/resiliencyoriented and evidence-based services through multi-year reform and development of centers of excellence
 - ✓ Massachusetts Advising Medicaid agency on "Rosie D" EPSDT reform.
 - ✓ Direct experience in other states CO, CT, FL, NM, TX, UT





Perspective on Project: Medicaid Trends

- > Understand current Medicaid funding context
 - ✓ Implications of 1997 BBA, 2005 Deficit Reduction Act
 - ✓ Issues for 1915(b)(3) states (WA, CO, CT, FL, NM, PA, UT)
 - ✓ Issues with recent State Plan Amendments
- > Medicaid State Plan versus Implementation
- Medicaid State Plan versus State Regulation
 - ✓ Goal of Medicaid State Plan is to maximize FFP.
 - ✓ Goal of State Regulation is to implement benefits
 - ✓ Examples of Arizona, Massachusetts, Pennsylvania





Three States' Approaches to Optional Rehabilitative Services

- > Benefits are defined in the "Limitations" section of Medicaid State Plan
- > Pennsylvania developed their definitions pre-managed care
 - Detailed definitions of two types of service in 2004: Crisis Intervention and Family Based Mental Health Services
 - ✓ Trying now to add Peer Support and Mobile Therapy
 - ✓ Most services are under 1915(b) Waiver
- ➤ Arizona developed their limitation post-managed care here is the total text of the limitations in their plan:

Rehabilitative Services provided by a behavioral health and/or substance abuse rehabilitation agency.

- Massachusetts: No limitations
- > What do AZ and MA do? They manage by state-level regulation





Perspective on Project: Evidence-Based Practices

- Understand EBPs & Promising Practices, including implementation issues involving cross-cultural applications
 - ✓ Adult EBPs ACT, IDDT, DBT, SE, Family Psychoeducation, Gatekeeper, MedMAP
 - ✓ Child EBPs FFT, MST, MTFC
 - Recovery/Resilience-focused Wraparound, WRAP Planning, Schoolbased, Peer Support, Clubhouse, Primary Care Integration
- > Evidence-based programs vs. practices vs. culture
 - ✓ Tension between EBPs and recovery/resiliency practices
 - ✓ Tension between EBPs and cultural competency
 - ✓ Difference between evidence-based programs versus practices
 - National focus has shifted to evidence-based culture



Evidence-Based Culture



- > Current research on EBP implementation: "Evidence-based Culture"
 - ✓ Dixon (2003), Barwick et al (2005), Rivard et al (2006)
 - ✓ Recognizes the need for system/organizational infrastructure to support the implementation and broad dissemination of evidence-based practices
- Key components include:
 - ✓ Involves all levels of the system state, regional, managers, clinicians
 - ✓ Begins a thorough understanding of the current treatment system
 - ✓ Systematic approach to review available evidence, recommend changes
 - ✓ Supports a reimbursement rate commensurate with implementation.
 - ✓ Provides reimbursement for needed training and clinical supervision
 - ✓ Data collection and reporting mechanisms to document EBP results





Evidence-Based Culture (continued)

- > Key components (continued):
 - ✓ Develops policies to facilitate adoption/implementation of EBPs
 - ✓ Bi-directional communication between researchers and clinicians
 - ✓ Appropriate balance between fidelity and adaptation
 - ✓ Uses outcome data to drive systems change.
- ➤ This research specifically shows that simply requiring EBPs hasn't worked and may in fact be counter-productive



Initial Analysis of Input from November Community Forum

- No service gaps were noted that seemed outside of current State Medicaid Plan
- > Issue was more "how" services are used than "what" services are used
- Eligibility was an issue some can change (Access to Care Standards), some cannot



Evidence Based Programs Versus Practices

- An evidence-based culture allows for differentiation between evidencebased programs and practices
 - ✓ The focus of most public sector efforts have been self-contained programs
 - ✓ However, most people receive services through practices embedded in traditional services (case management, individual treatment)
- > Examples
 - ✓ Integrated Dual Disorder Treatment 14 components, each with evidence
 - ✓ Hawkins and Catalano (1992) 7 elements based on evidence
- ➤ Both are needed recent Children's MH EBP Pilot is good example





Tension Between EBP and Consumer/Family Driven Practices

- Current transformation efforts often lead to tension between EBPs and Consumer/Family Driven Practices
 - ✓ Personal Assistance in Community Existence (PACE) Dan Fisher, PhD
 - ✓ If the is choice between PACT and Peer Support, guess which wins?
 - ✓ But the research shows the choice is between PACT and jail/hospital/street
- We see the two separate dimensions which can be applied to any practice
 - ✓ What is the degree of evidence of the practice?
 - ✓ How consumer/family driven is the practice?
- ➤ On the next page is an example based on the MHTG input of priority services THIS IS AN EXAMPLE ONLY this will be revised as we complete our literature summary

December 21, 2006

SAMPLE TABLE – For Illustration Purposes Only

Evidence → Consumer / Family Driven	ЕВР	Promising Practice	Emerging Evidence	Minimal Current Evidence	Evidence of No Benefit or Risk
Consumer Run and Operated		■ Clubhouse	 Attending Support Groups Social Supports / Community Connections / Natural Supports 	 Warm Lines by Consumer Organization Involvement in Advocacy Drop-In Center 	
Consumer Operated	Family Psychoeducation	 Wraparound Planning facilitated by Parents 	 WRAP Planning by Consumers Receive / Give Peer Support Parent Partners Youth as Mentors 	 Warm Lines by MH Center 	
Consumer Involvement	 Learning Self-Help Strategies (IMR) Supported Employment 	 Wraparound Planning facilitated by Professionals Supported Housing Supported Education 	 WRAP Planning by Professionals Mentors for Youth 	 Socialization Opportunities Other Illness / Wellness Education 	
Professional Run and Operated	 Cognitive Behavioral Therapy (CBT) Functional Family Therapy (FFT) Medication Management (MedMAP) Dialectical Behavioral Therapy (DBT) 	 Motivational Enhancement Therapy (MET) 	 Crisis Lines Respite Care Some Group Therapies Some Trauma / Abuse Counseling Psychiatrist Psychologist 	 Art Therapy Massage Therapy Acupuncture Undifferentiated Individual Treatment 	 Undifferentiated Day Treatment Undifferentiated Group Therapies

December 21, 2006





Andrew Keller, Ph.D. TriWest Group

FOR ANDY TO FILL OUT



Part 6: Wrap Up

- Plans for January Community Forum
- Forum table facilitators sign up
- Comments regarding today's meeting & process

